



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

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

JUN 28 2017

RE: SPA #17-0040
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #17-0040 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2017 (Appendix I). This amendment is being submitted based on State statute. A summary of the plan amendment is provided in Appendix II.

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


Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 29, 2017 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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 17-0040	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 April 1, 2017	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: § 1902(a) of the Social Security Act and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/17-09/30/17 \$ 84,750.00 b. FFY 10/01/17-09/31/18 \$ 84,750.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Page 2(c)(v.2)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: Page 2(c)(v.2)	
10. SUBJECT OF AMENDMENT: 2017 Voluntary UPL Payments - Outpatient (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
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 1432 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 28 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
Second Quarter Amendment
Amended SPA Pages

**New York
2(c)(v.2)**

**Additional Hospital Outpatient Supplemental Payment Adjustment – Voluntary
Sector Hospitals**

Effective for the period April 1, [2016] 2017 through March 31, [2017] 2018, additional hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, which can be made for outpatient hospital services after all other medical assistance payments, not to exceed in aggregate \$339,000,000 annually, in combination with the inpatient voluntary UPL SPA for the same period, subject to the requirements of 42 CFR 447.272 (upper payment limit). Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals

TN #17-0040

Approval Date _____

Supersedes TN #16-0045

Effective Date _____

Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0040

This State Plan Amendment proposes to extend supplemental payments made for outpatient hospital services to voluntary sector hospitals and in non-state public hospitals in cities with more than one million persons. These payments reflect specialty adjustments to qualifying hospitals, for the period April 1, 2017 through March 31, 2018.

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

Chapter 57 of the Laws of 2015 - Part E

§ 2. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for periods on and after April 1, 2015, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

**Appendix IV
2017 Title XIX State Plan
Second Quarter Amendment
Public Notice**

provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

- Effective on or after April 1, 2017, eliminates supplemental medical assistance payments of up to \$6 million annually made to providers of emergency medical transportation.
- Continues, effective for periods on and after April 1, 2017, funds to certified home health agencies, AIDS home care providers, and hospice service providers for the purpose of improving recruitment, training, and retention of home health aides or other personnel with direct patient care responsibility.

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 \$26 million.

- Extends current provisions to services on and after April 1, 2017 through March 30, 2020, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.
- Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2017 through March 31, 2020.

- Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

- Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$35.1) million.

Prescription Drugs:

- Effective April 1, 2017, in an effort to mitigate high drug costs, the Department proposes to establish requirements for manufacturers to pay a penalty in the form of a rebate, as well as impose a surcharge on wholesalers and manufacturers for certain high priced drugs.

- o The Department will collect confidential information from drug manufacturers related to drug costs and prices, and with the assistance of the drug utilization review board (DURB), identify for review drugs which: are first introduced to market at prohibitively expensive prices, experience a large increase in price not explained by a relevant factor, or are priced disproportionately given limited therapeutic benefits. If a manufacturer's price exceeds the reasonable value of the drug, as determined by the DURB, the Board would recommend that a benchmark price be established and the excess amount would be subject to a Medicaid rebate and a surcharge.

- o A list of such designated high priced drugs shall be published on the Department's website, along with the date on which each drug first appeared on the list, and its associated benchmark price.

- o A surcharge of 60% shall be imposed on the excess charge amount of the gross receipt from the first in-state sale of a high priced drug. The surcharge shall be deposited into a designated High Priced Drug Reimbursement Fund, and paid out through the Department of Financial Services to health insurers and the Medicaid program in proportion to their respective costs attributable to the drug.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$110 million.

- The Department proposes to amend the reimbursement for prescription drugs dispensed, effective April 1, 2017. These changes will bring the reimbursement methodology into compliance with Federal regulations.

- o Reimbursement for prescribed drugs will be the lower of ingredient cost (plus a professional dispensing fee when a covered outpatient drug), or the billing pharmacy's usual and customary charge.

- o For brand name drugs, the ingredient cost will be the National Average Drug Acquisition Cost (NADAC); or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC) less 3.3%.

- o For generic drugs, ingredient cost will be the lower of NADAC; or the Federal Upper Limit (FUL); or the State Maximum Acquisition Cost (SMAC). In the event of no NADAC pricing available, ingredient cost is the lower of WAC less 17.5%; or the FUL; or SMAC.

- o For over-the-counter drugs, ingredient cost will be the lower of NADAC; or FUL; or SMAC. In the event of no NADAC pricing available, ingredient cost is the lower of WAC; FUL; or SMAC.

- o The professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be \$10.00.

The estimated annual aggregate increase in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$11 million.

- Effective July 1, 2017, the co-pay for over-the-counter (OTC) non-prescription drug/items will be increased from \$0.50 to \$1.00. In addition, modifications to the list of covered drug/items in this category may be filed as regulations by the commissioner of health without prior notice and comment.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$12.6 million.

- Effective July 1, 2017, the Department proposes to amend the copayment for brand name prescription drugs dispensed in order to eliminate the difference in co-pay between a preferred drug and a non-preferred drug, in accordance with federal requirements:

- o The co-pay for brand-name prescription drugs will be changed to \$2.50, regardless of their status on or off the preferred drug list; provided, however, that the copayments for brand name prescriptions drugs in the Fee-for-Service Brand Less Than Generic program will continue to be \$1.00.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendments.

The overall estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2017/2018 is \$282,506,637 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of upper payment limit (UPL) payments for state fiscal year 2017/2018 in \$2.5 billion.

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

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0040

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. Private providers do not return to the State any amount or percentage of the payment. 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 Office of Management and Budget Circular 2 CFR 200 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 Medicaid payments authorized for this provision are supplemental payments. The amount of the supplemental payment for voluntary hospitals for the period April 1, 2017 through March 31, 2018 is \$339M.

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: Based on guidance from CMS, the State will submit the current outpatient UPL demonstration based on the outcome of strategic plan discussions.

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

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

ACA Assurances:

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

MOE Period.

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

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

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

expenditures at a greater percentage than would have been required on December 31, 2009.

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

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

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

Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.