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

June 28, 2019

Mr. Ricardo Holligan
Acting 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 #19-0019
Non-Institutional Services

Dear Mr. Holligan:

The State requests approval of the enclosed amendment #19-0019 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on State Regulations. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of State Regulations is 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 27, 2019, 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 Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 0019

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/19-09/30/19 $ 1,800.00
b. FFY 10/01/19-09/30/20 $ 3,600.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Page 10(1)(A)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Page 10(1)(A)

10. SUBJECT OF AMENDMENT
Early Intervention Targeted 5% Rate Increase
(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
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
June 28, 2019

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

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

Instructions on Back

Appendix I
2019 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

Rehabilitative Services

[Reimbursement for approved early intervention providers is associated with resource use patterns to ensure that evaluations and early intervention services are economically and efficiently provided. The method is based on a classification of early intervention services.

Under the reimbursement methodology, individual or combined prices are established prospectively for each service category. For each service category, a price is established to cover labor, administrative overhead; general operating and capital costs. The prices are adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in the Wage Equalization Factor section of this Attachment. All prices are subject to the approval of the New York State Division of the Budget.

Existing rates of reimbursement, for approved early intervention services provided on and after December 1, 2002, shall be increased by three percent. The Commissioner of Health is authorized to require any early intervention provider, with the exception of self-employed early intervention providers, to submit a written certification attesting that such funds were or will be used solely for the purpose of recruitment and retention of early intervention service providers during the 2002-03 state fiscal year.

Effective May 1, 2011, and applicable to services on and after May 1, early intervention program rates for approved services rendered will be reduced by 5%. Prices resulting from this reduction are published on the agency's website at:]

Effective April 1, 2019, and applicable to services on and after April 1, 2019, early intervention rates for EPSDT EI rehabilitation services rendered by licensed speech-language pathologists, licensed occupational therapists and licensed physical therapists, including supplemental evaluation services, will be increased by 5%. Rates effective April 1, 2019 are published on the Department of Health's website below.

http://www.health.state.ny.us/community/infants_children/early_intervention/index.htm

The rates for Early Intervention services are the same for both governmental and private providers.

[Early Intervention service providers who were authorized to provide early intervention services pursuant to section 236 of the Family Court Act during 1993, shall be reimbursed actual allowable capital costs obligated prior to July 1, 1993. Such reimbursement will continue through June 30, 1996.]

Appendix II
2019 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #19-0019

This amendment proposes to revise the State Plan to increase the reimbursement rates for rehabilitation services rendered by certain licensed professionals: Speech Language Pathologists, Occupational Therapists and Physical Therapists. The increase also applies to supplemental evaluations performed by these licensed professionals. Rates for these services have not been increased since 2011.

Appendix III
2019 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

10 CRR-NY 69-4.30
NY-CRR

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 10. DEPARTMENT OF HEALTH
CHAPTER II. ADMINISTRATIVE RULES AND REGULATIONS
SUBCHAPTER H. FAMILY HEALTH
PART 69. TESTING FOR PHENYLKETONURIA AND OTHER DISEASES AND CONDITIONS/EARLY INTERVENTION PROGRAM/NEWBORN HEARING SCREENING/STANDARD INFANT AUTOPSY PROCEDURES
SUBPART 69-4. EARLY INTERVENTION PROGRAM

10 CRR-NY 69-4.30
10 CRR-NY 69-4.30

69-4.30 Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers.

(a) The commissioner shall annually determine the rates for approved early intervention services and evaluations provided to eligible children, subject to the approval of the Director of the Budget. For payments made pursuant to this section for early intervention services to Medicaid patients, reimbursement shall be based upon a uniform payment schedule with discrete prices as set forth ine subdivision (d) of this section. To be eligible to receive reimbursement pursuant to this section, providers must be approved to provide early intervention services pursuant to article 25 of the Public Health Law.

(b) For purposes of this section, *a billable visit* shall mean a face-to-face contact for the provision of authorized early intervention services between a provider of early intervention services and the individual(s) receiving such services, except for service coordination as described in paragraph (c)(3) of this section. *Duration* shall mean the time spent by a provider of early intervention services providing direct care or client contact. Activities such as case recording, training and conferences, supervisory conferences, team meetings and administrative work are not separately billable activities.

(c) Reimbursement shall be available at prices established pursuant to this section for the following Early Intervention Program services:

(1) *Screening* as defined in section 69-4.1(an) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. A provider shall submit one claim for a screening regardless of the number of visits required to perform and complete a screening. Reimbursement may be provided for up to two screenings of a child suspected of having a developmental delay in any 12-month period without prior approval of the early intervention official. The early intervention official shall approve any additional screenings provided to a child within the 12-month period. Reimbursement shall not be provided for screenings performed after a child has been found eligible for early intervention services.

(2) *Multidisciplinary evaluation* as defined in section 69-4.1(n) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. Reimbursable evaluations shall include core evaluations and supplemental evaluations. A provider shall submit one claim for a core or supplemental evaluation regardless of the number of visits required to perform and complete the evaluation.

(i) A *core evaluation* shall include a developmental assessment, a review of pertinent records and a parent interview as specified in section 69-4.8(a)(4) of this Subpart, and may include a family assessment.

(a)eA *developmental assessment* shall mean procedures conducted by qualified personnel with sufficient expertise in early childhood development who are trained in the use of professionally acceptable methods and procedures to evaluate each of the developmental domains: physical development, cognitive deveiopment, communication development, social or emotional development and adaptive development.

(b) A *family assessment* shall mean a voluntary, family-directed assessment conducted by qualified personnel who are trained in the use of professionally acceptable methods and procedures to assist the family in identifying their concerns,e priorities and resources related to the development of the child.e

(ii) *Supplemental evaluations* shall include supplemental physician or non-physician evaluations and shall be provided upone the recommendation of the multidisciplinary team conducting the core evaluation and agreement of the child's parent. A supplemental evaluation may also be provided in conjunction with the core evaluation by a specialist trained in the area of the child's suspected delay or disability who is present during the core evaluation as required by section 69-4.8(a)(3) of this Subpart and who provides an in-depth assessment of the child's strengths and needs in such area. Supplemental evaluations provided subsequent to the child's Individualized Family Service Plan (IFSP) must be required by and performed in accordance with the IFSP as specified in section 69-4.8(a)(13) of this Subpart.

(a) *Supplemental physician evaluation* shall mean an evaluation by a physician licensed pursuant to article 131 of the Education Law for the purpose of providing specific medical information regarding physical or mental conditions that may impact on the growth and development of the child and completing the required evaluation of the child's physical development as specified in section 69-4.8(a)(4)(i)(a) of this Subpart, or assessing specific needs in one or more of the developmental domains in accordance with section 69-4.8(a)(4)(iv) of this Subpart.

(b) *Supplemental non-physician evaluation* shall mean an additional evaluation for assessing the child's specific needs in one or more of the developmental domains in accordance with section 69-4.8 of this Subpart. Information obtainede from this evaluation shall provide direction as to the specific early intervention services that may be required for thee child. Supplemental non-physician evaluations may be conducted only by qualified personnel as defined in section 69-4.1(al) of this Subpart.

(iii)

(a) A multidisciplinary evaluation consisting of a core evaluation and up to four supplemental evaluations (which may include any combination of physician and non-physician evaluations) may be reimbursed within a 12-month period without prior approval of the early intervention official to develop and implement the initial Individualized Family Service Plan (IFSP) and subsequent annual IFSPs. The early intervention official shall approve and notify the department of any additional core or supplemental evaluations provided to a child within the initial 12-month period. If additional core or supplemental evaluations are necessary, such notice shall be provided on a monthly basis on forms provided by the department. Additional core or supplemental evaluations provided subsequent to the child's initial IFSP must be required by and performed in accordance with the IFSP as specified in section 69-4.8(a)(13) of this Subpart.

(b) Certain evaluation and assessment procedures may be repeated if deemed necessary and appropriate by the early intervention official in conjunction with the required annual evaluation of the child's IFSP or more frequently ine accordance with section 69-4.8(a)(12) of this Subpart. If additional evaluation or assessment procedures are necessary, the early intervention official shall approve up to one more core evaluation and two supplemental evaluations prior to the next annual IFSP. Such additional evaluations must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8(a)(13) of this Subpart. Any additional evaluations within that period shall be based on the indicators specified in section 69-4.8(a)(12) of this Subpart, approved by the early intervention official and the Commissioner of Health of the New York State department of Health and required by and performed in accordance with the child's IFSP.

(3)e*Service coordination* as defined in section 69-4.1(m)(2)(xii) of this Subpart. Service coordination shall be provided by appropriate qualified personnel and billed in 15 minute units that reflect the time spent providing services in accordance with sections 69-4.6 and 69-4.7 of this Subpart, or billed under a capitation or other rate methodology as may be established by the commissioner subject to the approval of the Director of the Budget and as specified in prior written notice provided by the Commissioner to Early Intervention Officials. Such written notice shall specify that any newly established rate methodology shalle apply only to initial IFSPs and IFSP amendments made on or after the effective date of such written notice by the commissioner. The rate methodology may be established on a per month, per week, and/or service component basis for providing service coordination services. When units of time are billed, the first unit shall reflect the initial five to 15 minutes of service provided and each unit thereafter shall reflect up to an additional 15 minutes of service provided. Except for child/family interviews to makee assessments and plans, contacts for service coordination need not be face-to-face encounters; they may include contacts withe service providers or a child's parent, caregiver, daycare worker or other similar collateral contacts, in fulfillment of the child'se IFSP.

(4) *Assistive technology* as defined in section 69-4.1(m)(2)(ii) of this Subpart.

(5) Home and community-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or parent(s) or other designated caregiver at the child's home or other natural setting in which children under three years of age are typically found (including day care centers, other than those located at the same premises as the early intervention provider, and family day care homes). Reimbursable home and community-based individual/collateral visits shall include basic and extended visits.

(i) A basic visit is less than one hour in duration. Up to three such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval ofe the early intervention official.

(ii) An extended visit is one hour or more in duration. Up to three such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official.

(iii) Notwithstanding subparagraphs (i) and (ii) of this paragraph, no more than three basic and extended visits combined pere day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official.

(iv) A provider shall not bill for a basic and extended visit provided on the same day by appropriate qualified personnel within the same discipline without prior approval of the early intervention official.

(6) Office/facility-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or parent(s) or other designated caregiver at an approved early intervention provider's site (including day care centers located at the same premises as the early intervention provider). Up to one visit pere

discipline and no more than three office/facility-based visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official.

(7) Parent-child group visit. This shall mean the provision of early intervention services in a group comprised of parent(s) or other designated caregivers and eligible children, and a minimum of one appropriate professional qualified to provide early intervention services at an early intervention provider's site or a community-based site (*e.g.* day care center, family day care, or othere community settings). Up to one visit per day may be billed for each eligible child as specified in an approved IFSP without priore approval of the early intervention official.

(8)eBasic group developmental intervention visit. This shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found.e

(i) Up to one group developmental intervention visit per day may be billed for each eligible child as specified in an approvede IFSP without prior approval of the early intervention official.e

(ii) For purposes of subparagraph (i) of this paragraph and subparagraphs (i) of paragraphs (9) through (11) of this subdivision, a group developmental intervention visit shall include a basic visit as described in this paragraph, an enhanced visit as described in paragraph (9) of this subdivision, a basic with one-to-one aide visit as described in paragraph (10) of thise subdivision, or an enhanced with one-to-one aide visit as described in paragraph (11) of this subdivision.e

(9) Enhanced group developmental intervention visit. This shall mean a group developmental intervention visit as defined in paragraph (8) of this subdivision provided to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official.

(10)eBasic group developmental intervention with one-to-one aide visit. This shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, with attendance at the group developmental intervention session by an additional aide or appropriate qualified personnel. This visit must be provided at an approved early intervention provider's site or in a community-based setting where children under three years of age are typically found.

(i) Up to one group developmental intervention visit per day may be billed for each eligible child as specified in an approvede IFSP without prior approval of the early intervention official.e

(11) Enhanced group developmental intervention with one-to-one aide visit. This shall mean a group developmental intervention with one-to-one aide visit as defined in paragraph (10) of this subdivision provided to a child who, due to age, significant medical needs (such as major feeding difficulties, severe orthopaedic impairment), significant behavior management needs and/or level of developmental functioning, require significantly more time and attention from adults during group activities.

(i) Up to one group developmental intervention visit per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official.

(12) Family/caregiver support group visit. This shall mean the provision of early intervention services by appropriate qualifiede personnel to a group of parents or other designated caregivers (such as foster parents, day care staff) and/or siblings of eligiblee children for the purposes of:

(i) enhancing their capacity to care for and/or enhance the development of the eligible child; and/or

(ii) provide support, education, and guidance to such individuals relative to the child's unique developmental needs. Up to two visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the early intervention official (for example, one for parents or other designated caregivers and one for sibling[s] in a given day).

(13) ABA services. This shall mean services delivered by an ABA aide employed by and under the supervision of an agency provider approved in accordance with section 69-4.25 of this Subpart to deliver ABA services in accordance with requirements set forth in section 69-4.25 of this Subpart. The price established pursuant to this section shall include direct and indirect supervisory time, team meetings and training. ABA services shall be billed by the day and in increments of 60 minutes up to and in accordance with the hours of service as specified the child's IFSP.

(14) The early intervention official shall approve and notify the department of any visits provided in addition to those described ine paragraphs (5) through (12) of this subdivision as may be required by and provided in accordance with the child's IFSP. If suche additional visits are necessary, such notice shall be provided on a monthly basis on forms provided by the department.

(d) The prices established pursuant to this section shall provide full reimbursement for the following:

(1) physician services, nursing services, therapist services, technician services, nutrition services, psychosocial services, service coordination, and other related professional and paraprofessional expenses directly incurred by the approved provider;

(2) space occupancy, except as provided in subdivision (f) of this section, and plant overhead costs;

(3) all supplies directly related to the provision of early intervention services, except as provided in subdivision (g) of this section; and

(4) administrative, personnel, business office, data processing, recordkeeping, housekeeping, and other related provider overhead expenses.

(e) The price for each service shall be adjusted for regional differences in wage levels to reflect differences in labor costs for personnel providing direct care and support staff and shall include consideration of absentee data and child to professional to paraprofessional ratios.

(f) Assistive technology devices.

Reimbursement for approved assistive technology devices shall be at reasonable and customary charges approved by the commissioner or his designee.

10 CRR-NY 69-4.30
Current through December 15, 2018

END OF DOCUMENT

Appendix IV
2019 Title XIX State Plan
Second Quarter Amendment
Public Notice

Bernard Fineson DDRO
PO Box 280507
Queens Village, NY 11428-0507

Metro NY DDRO/Bronx
2400 Halsey St.
Bronx, NY 10461

Brooklyn DDRO
888 Fountain Ave.
Bldg. 1, 2nd Floor
Brooklyn, NY 11239

Metro NY DDRO/Manhattan
25 Beaver St., 4th Floor
New York, NY 10004

Staten Island DDRO
1150 Forest Hill Rd.
Bldg. 12, Suite A
Staten Island, NY 10314-6316

Long Island DDRO
415-A Oser Ave.
Hauppauge, NY 11788

For further information and to review and comment, please contact: Office for People With Developmental Disabilities, Division of Person-Centered Services, Waiver Unit, 44 Holland Ave., Albany, NY 12229, Peoplefirstwaiver@opwdd.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, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

All Services

Effective on or after April 1, 2019 through March 31, 2021 all non-exempt Medicaid payments, as referenced below, will be uniformly reduced. Such reductions will be applied only if an alternative method that achieves at least $190.2 million in Medicaid state share savings annually is not implemented.

Exemptions from the uniform reduction are as follows:

- Any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal Medicare program;
- Payments pursuant to the mental hygiene law;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- Payments where applying the reduction would result in a lower Federal Medical Assistance Percentage as determined by the Commissioner of Health and the Director of the Budget.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is ($380.4 million).

Effective on and after April 1, 2019, no greater than zero trend factors attributable to services through March 31, 2024 pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, for certified home health agencies, long term home health care programs, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is ($208.8 million).

Non-Institutional Services

Effective on or after April 1, 2019, the reimbursement rate for Early Intervention services furnished by licensed physical therapists (PTs), occupational therapists OTs), and speech-language pathologists (SLPs) will increase by 5%. This increase would also apply to supplemental evaluations performed by licensed PTs, OTs and SLPs. These rates are being revised to address capacity issues that municipalities are facing statewide for these qualified professionals.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/20 is estimated to be $7.2 million.

Effective on or after April 1, 2019, 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.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is ($35.1 million).

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, the reimbursable operating cost component for general hospital inpatient rates will be established with

Appendix V
2019 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #19-0019

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 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 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: The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Response: Question is not applicable as Early Intervention services are not clinic or outpatient hospital services.

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

   Response: The rate methodology included in the State Plan for Early Intervention Services is a prospective methodology. 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 17-0065, 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.