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

March 24, 2020

Ms. Nicole McKnight
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 #20-0016
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #20-0016 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2020 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation 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 December 31, 2019, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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: 20-0016

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
January 1, 2020

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 01/01/20-09/30/20 $ (17,099.44)
b. FFY 10/01/20-09/30/21 $ (22,799.26)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 B: Pages A(7.5), A(7.6), A(7.7)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT
ATB-Non-Institutional
(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
March 24, 2020

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

Appendix I
2020 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
A (7.5)

Across the Board 1% Payment Reduction – effective 1/1/2020 and thereafter

(1) For dates of service on and after January 1, 2020, payments for services as specified in paragraph (2) of this Attachment will be reduced by 1%, with the exception of the services listed below that are provided in clinics designated as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services, as well as services provided to Native Americans, where applicable.

(2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

a) Physician Services.	Page 1 - 1.0
b) Statewide Patient Centered Medical Home, Advanced Primary Care and the Adirondack Medical Home Multipayor Program for physicians, nurse practitioners, hospital-based clinics and freestanding clinics.	Pages 1(A) - 1(A)(iii); 1(c)(i)(A) - 1(c)(i)(H)
c) Reimbursement fees for dental services, podiatrists, optometrists, chiropractor services, nurse midwives, nurse practitioners and clinical psychologists.	Page 1(a)
d) Outpatient Reimbursement for Acute Care Children's Hospitals.	Page 1(b)(i)(1)(a)
e) Ordered Ambulatory Services.	Pages 1(c) - 1(c)(i)
f) Adult Day Health Care Services rendered to patients with HIV/AIDS which are provided in Freestanding Clinics certified under Article 28 of the NYS Public Health Law.	Pages 1(d); 2 - 2(a)
g) Ambulatory Patient Group (APG) reimbursement for hospital outpatient departments, emergency departments and ambulatory surgery services.	Pages 1(e)(1) - 1(e)(3); 1(f) - 1(l)(ii)
h) Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis.	Page 2
i) Voluntary Upper Payment Limit (UPL) payments for voluntary hospitals certified under Article 28 of the NYS Public Health Law.	Page 2(c)(v.2)
j) Ambulatory Patient Group (APG) reimbursement for freestanding clinic and ambulatory surgery center services.	Pages 2(g)(1) - 2(p)(iv)
k) Laboratory Services.	Page 4

New York
A (7.6)

l) Home Health Services provided by Certified Home Health Agencies (CHHAs), including services to patients diagnosed with AIDS.	Pages 4(1) - 4(9); 4(a) - 4(a)(i)(A); 4(a)(viii)(1)
m) Personal Emergency Response Services (PERS).	Page 4(a)(i)(3)
n) Services Provided to Medically Fragile Children.	Page 4(a)(i)(3)
o) Home Telehealth Services provided by CHHAs including those that provide AIDS home care services.	Pages 4(a)(i)(4) – 4(a)(i)(5)
p) Telehealth store and forward technology services and remote patient monitoring.	Page 4(a)(i)(6)
q) Assisted Living Programs (ALPs).	Pages 4(c)(1) - 4(c)(2)
r) Outpatient Drug Reimbursement.	Pages 4(d) - 4(e)
s) Pharmacists as immunizers and Diabetes Self-Management Training (DSMT).	Page 4(f)(1)
t) Private Duty Nursing, including nursing services provided to medically fragile children and services provided to eligible residents of an adult home or enriched housing program that is issued a limited license by the Department of Health.	Pages 5 - 5(a)(i)
u) Physical Therapy and Occupational Therapy.	Page 5(a)(i)
v) Eyeglasses and other visual services, hearing aid supplies and services and prosthetic and orthotic appliances.	Page 5(b)
w) Orthopedic footwear.	Page 5(b)(1)
x) Durable Medical Equipment (DME)	Page 6
y) Medical/Surgical Supplies.	Page 6
z) General Formula.	Page 6
aa) Transportation.	Page 6
bb) Out-of-State Services for fee-based providers.	Page 6(a)
cc) Personal Care Services.	Pages 6(a)(1) – 6(a)(7); 6(a)(i)(2)

New York
A (7.7)

dd) Community First Choice Option Services.	Pages 6(a)(v) – 6(a)(ix)
ee) Adult Day Health Care Facilities	Pages 7(a) – 7(b)(iii)
ff) Case Management Services to Target Group F, Target Groups A and E, Target Group C and Target Group M.	Pages 10(4) – 10(5)(a); 11 – 11(C); 11(g)
gg) Harm Reduction Services.	Pages 11(h) – 11(i)
hh) Preferred Physician and Children's Program.	Pages 12(2) – 12(3)
ii) Medicaid Obstetrical and Maternal Services (MOMS).	Page 12(4)
jj) Child Teen Health Program (CTHP).	Page 12(5)
kk) Emergency services for illegal aliens.	Page 13
ll) Early and periodic screening, diagnostic and treatment services (EPSDT).	Page 17(e) – 17(i)
mm) National Diabetes Prevention Program (NDPP).	Page 19

Appendix II
2020 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #20-0016

This amendment proposes to revise the State Plan to apply a 1% reduction uniformly across most payments made under the State's Non-Institutional State Plan section 4.19-B for dates of service effective January 1, 2020 and thereafter.

Appendix III
2020 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 20-0016

Chapter 53 of the Laws of 2019
2019/20 Appropriation Bill
(S1503-D / A2003-D) Aid to Localities Budget Bill

Notwithstanding and provision of law to the contrary, the director of the budget, in consultation with the commissioner of health, may use a payment reduction plan to make across-the-board reductions to the department of health state funds medicaid spending by $190,200,000 for each of the state fiscal years 2019-2020 and 2020-2021 to limit such spending to the aggregate limits specified herein, or reduce the aggregate limits specified herein to provide a reduction to the State's Financial Plan. Reductions shall be made in a manner that complies with the state medicaid plan approved by the federal centers for medicare and medicaid services, provided, however, that the commissioner of health is authorized to submit any state plan amendment or seek other federal approval to implement the provisions of the medicaid payment reduction plan.

Appendix IV
2020 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 Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long term care services to comply with proposed statutory provisions. The following changes are proposed:

All Services

Effective for dates of service on or after January 1, 2020, through March 31, 2020, and each State Fiscal Year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by 1.0%. Medicaid payments that will be exempted from the uniform reduction include:

Payments based on federal law prohibitions include, but are not limited to, the following:

- Federally Qualified Health Center services;
- Indian Health Services and services provided to Native Americans;
- Supplemental Medical Insurance – Part A and Part B;
- State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
- Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
- Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
- Services provided to American citizen repatriates;
- Payments pursuant to the mental hygiene law;
- Court orders and judgments; and
- Hospice Services.

Payments funded exclusively with federal and/or local funds include, but are not limited to the following:

- Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
- Certified public expenditure payments to the NYC Health and Hospital Corporation;
- Certain disproportionate share payments to non-state operated or owned governmental hospitals;
- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.

Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will also be exempt.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2019-20 is ($124,000,000) and ($496,000,000) for each State Fiscal Year thereafter.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at: http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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 1432, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for all qualifying Mental Hygiene services to comply with enacted statutory provisions. The following changes are proposed:

Long Term Care

Effective on or after January 1, 2020, the State will change the methods and standards for determining payment rates for all qualifying Mental Hygiene Services to provide funding to support a two percent increase in annual salary and salary-related fringe benefits to direct care staff and direct support professionals.

Effective on or after April 1, 2020, a new two percent increase in annual salary and salary-related fringe benefits will be applied to direct care staff, direct support professionals and clinical staff for all qualifying Mental Hygiene Services. For the purposes of the January 1 and April 1, 2020, funding increases, direct support professionals are individuals employed in consolidated fiscal reporting position title codes ranging from 100 to 199; direct care staff are individuals employed in consolidated fiscal reporting position title codes ranging from 200 to 299; and clinical staff are individuals employed in consolidated fiscal reporting position title codes ranging from 300 to 399.

The estimated annual net aggregate increase in gross Medicaid expenditure attributable to this initiative enacted into law as part of the budget for SFY 2019/2020 is $140 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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, Fax (518) 473-8825, spa_inquiries@health.state.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 services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology and Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) fees. The following changes are proposed:

Non-Institutional

For the effective period January 1, 2020 through December 31, 2020, the Ambulatory Patient Group (APG) reimbursement methodology is extended.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $0.

Effective on or after January 1, 2020, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $3.87 million.

Effective on or after January 1, 2020, the Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) fees are revised.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $0.

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, Fax (518) 473-8825, spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Nassau County

The Deferred Compensation Plan for Employees of Nassau Health Care Corporation (the "Plan"), a 457(b) plan created under the laws of the State of New York and pursuant to Section 457(b) of the Internal Revenue Code, is seeking proposals from qualified firms to:

Provide consulting services to the Plan regarding monitoring the performance of the current plan record keeper/administrative service agent, investment manager, and trustee, and overall plan investment performance.

Proposals will be accepted until 4:00 p.m. on Monday, February 10, 2020.

A copy of the Request for Proposals may be obtained during normal business hours (9:00 a.m. to 5:00 p.m. – Weekdays) from: Richard

Appendix V
2020 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #20-0016

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: The state and CMS are working toward completing and approval of current year UPL.

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 approved State Plan for non-institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider 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.

Appendix VI
2020 Title XIX State Plan
First Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment # 20-0016

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to apply a one percent (1%) reduction uniformly across most payments made under the State's Non-Institutional State Plan section 4.19-B, effective for dates of service beginning January 1, 2020 and thereafter. While this is a reduction in reimbursement, it reflects a minimal change for providers, and is being uniformly applied so there will be no major impacts to the payments made for provision of services.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. Certain classes of providers must notify and receive approval from the Department's Office of Primary Care and Health Systems Management in order to discontinue services. This office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

   Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: This change was enacted by the State Legislature as part of the negotiation of the 2019-20 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comment.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: The State has undertaken a massive reform initiative to better align reimbursement with care. This initiative invests funds in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. The State offers other programs to hospitals, such as the Vital Access Provider (VAP) program and the Vital Access Provider Assurance Program (VAPAP), to help sustain key health care services. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.