NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 3 0 2015

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #15-0001
Outpatient Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0001 to the Title XIX (Medicaid) State Plan effective June 1, 2015 (Appendix I).

A summary of the plan amendment is provided in Appendix II. Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III).

If you or your staff have any questions or need any assistance, please contact Karla Knuth of my staff at (518) 473-4665.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **15-0001**	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 **June 1, 2015**	

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: **§ 1906 of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **a. FFY 06/01/15 – 09/30/15 $ .00** **b. FFY 10/01/15 – 09/30/16 $ .00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.22-C: Page 1; Page 2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.22-C: Page 1; Page 2**

10. SUBJECT OF AMENDMENT:
Cost Effectiveness
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 30 2015	

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
2015 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New York

Citation: 1906 of the Act

Condition or Requirement: State Method of Cost Effectiveness of Employer-Based Group Health Plans

[The determination of cost benefit for any health insurance policy is an evaluation of many varied but interrelated criteria. It is difficult to establish exact guidelines for cost benefit determinations that can be applied uniformly in all cases. Unless a person is already in poor health, whenever insurance is purchased a risk is taken as to whether or not health expenses will be incurred. Therefore, cost benefit determinations must be made on an individual basis after the local district or Department of Health staff obtain information about the insurance policy and the individual applying for premium payment. If the average Medicaid payment is known for certain demographics (e.g., sex, age, location), cost effectiveness for paying the premium can be easily determined by comparing that cost to the cost of a premium for the same demographics.]

[Please note that for some cases, even after reviewing these criteria, the determination to pay for a health insurance policy may still be unclear. In these cases, the final decision will rest solely on the judgement of local district or Department of Health staff.]

Medicaid recipients in New York State are required to enroll in a Medicaid managed care plan unless they are considered an exempted or excluded population, or if they can enroll in free or cost effective employer-based group health insurance.

I. The following points should be considered at the time of determination and redetermination for coverage provided through employer-based group health plans for individuals required to enroll in Medicaid managed care.

1. Assess the types of medical services covered by the health insurance policies. In order for Medicaid to pay premiums for employer-based group health plans, the plans must include a comprehensive set of benefits including: inpatient care, home health, emergency room, clinic, physician, pharmacy, substance abuse, psychiatric, ex-ray, lab and end of life care.

2. Compare the monthly Medicaid recipient's share of the employer group plan premium, yearly deductible, the cost of Medicaid wrap around services; dental, vision, transportation and durable medical equipment, plus an administrative fee to the monthly Medicaid managed care rate for the individual.

3. If the cost for the employer group plan is less than the cost of the Medicaid managed care rate, the employer group health plan meets the criteria for premium reimbursement.

II. The following points should be considered at the time of determination and redetermination for individuals exempted or excluded from managed care:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New York

1. Assess the types of medical services covered by the health insurance policies. In order for Medicaid to pay premiums for employer-based group health plans, the plans must include a comprehensive set of benefits including: inpatient care, home health, emergency room, clinic, physician, pharmacy, substance abuse, psychiatric, ex-ray, lab and end of life care.

2. Has there been a high utilization of medical services by the applicant/recipient (A/R)? Request the A/R [applicant/recipient to bring to the interview all] provide medical bills (paid and unpaid), statements of insurance benefit payments (EOB's) and premium notice for the past year. Determine the total amount paid by all parties for the medical services.

3. Can the past utilization of medical expenses be expected to continue or increase?

    - [During the interview, inquire if any] Does an existing acute or chronic medical condition[s exist. If so, does the condition] require, or could it potentially require extensive medical services? Will these potential expenses be covered by the policy?

[4. Does a situation exist which warrants maintaining the policy even though there is no history of high medical utilization.]

[Due to the client's age or a pre-existing condition, is it reasonable to assume that the client may not be able to obtain another policy in the future or that a pre-existing condition would not be covered by a new policy for a period where medical utilization may be expected?]

4. For policies in force, what are the maximum benefit levels of the policy?

    - Have the maximum benefit levels been met, rendering the A/R ineligible for benefits?

    - If so, is the maximum benefit recurring? Will it be reinstituted on an annual basis, at the end of a specific benefit period, or does it apply separately to unrelated injuries, sicknesses, and/or conditions?

    - If there will be benefits or recurring benefits that will pertain to the A/R's potential medical expenses, how do these benefits compare to the cost of the premium?

5. Review the number of dependents in the family. In general, the larger the family, the more cost beneficial it is to purchase family coverage.

6. Compare the cost of the premium to the cost of all medical services received by the applicant/ recipient in the previous year (see #[2]II.3). Using this comparison and the other factors related to anticipated future utilization ([3]4 through 6) decide whether or not it is cost beneficial to maintain the policy. That is, does the cost of the premium payment and cost-sharing amounts appear likely to be less than Medicaid expenditures for an equivalent set of services?

[Note: For those districts that use the "Health Insurance Cost Appraisal Program (HICAP)" make sure that the premium payment used in the calculation is the Medicaid portion of the premium payment.]

Appendix II
2015 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #15-0001

This State Plan Amendment proposes to modify the existing determination of cost benefit of employer-based group health plans. The existing cost benefit determination relies on averaging Medicaid claims for certain demographics over a period of time. These averages have become less reflective of true Medicaid costs as more Medicaid eligibles are receiving services through mandatory managed care enrollment. The modified cost benefit analysis for this population will compare the cost of Medicaid managed care premiums to the cost to the employer-based group health plan premiums.

Appendix III
2015 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Social Services

§ 367-a. Payments; insurance. 1. (a) Any inconsistent provision of this chapter or other law notwithstanding, no assignment of the claim of any supplier of medical assistance shall be valid and enforceable as against any social services district or the department, and any payment with respect to any medical assistance shall be made to the person, institution, state department or agency or municipality supplying such medical assistance at rates established by the appropriate social services district and contained in its approved local medical plan, except as otherwise permitted or required by applicable federal and state provisions, including the regulations of the department; provided, however, that for those districts for whom the department has assumed payment responsibilities pursuant to section three hundred sixty-seven-b of this chapter, rates shall be established by the department, except as otherwise required by applicable provisions of federal or state law. A social services official may apply to the department for local variations in rates to be applicable, upon approval by the department, to recipients for whom such district is responsible. Claims for payment shall be made in such form and manner as the department shall determine.

(b) Where an applicant for or recipient of public assistance or medical assistance has health insurance in force, is enrolled in a group health insurance plan or group health plan covering care and other medical benefits provided under this title, payment or part-payment of the premium, co-insurance, any deductible amounts and other cost-sharing obligations for such insurance may also be made when deemed cost-effective pursuant to the regulations of the department.