NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

March 28, 2013

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

RE: SPA #12-29
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-29 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2013 (Appendix I). This amendment is being submitted based on existing Public Health Law. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of existing State statute is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on December 26, 2012, 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 matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

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: **12-29**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2013**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/13-09/30/13 $ 0** **b. FFY 10/01/13-09/30/14 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Page 110(d)(21), 110(d)(22), 110(d)(23), 110(d)(24), 110(d)(25)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Nursing Home Quality Incentive
(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 Oper & 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: March 28, 2013	

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
2013 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

New York
110(d)(21)

a) For the calendar year 2012, the operating component of the price of each non-specialty facility that fails to submit to the Commissioner a timely and properly certified 2011 nursing home cost report and nursing home employee flu immunization data for September 1, 2011 through March 31, 2012 shall be subject to a per diem reduction. The per diem reduction shall be calculated as follows:

(Number of Medicaid Days of the non-specialty facility that fails to report/ total Medicaid days of all non-specialty facilities) * $50 million

For the calendar year 2013, the Commissioner shall calculate a quality score for each non-specialty facility. For purposes of calculating a 2013 quality score, non-specialty facilities shall exclude non-Medicaid facilities, CMS Special Focus Facilities, Continuing Care Retirement Center Facilities, and Transitional Care Units. The quality score for each such non-specialty facility shall be calculated using the following Quality, Compliance, and Potentially Avoidable Hospitalizations Measures.

	Quality Measures
1	Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner)
2	Percent of Long Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine
3	Percent of Long Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine
4	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
5	Percent of Long Stay Residents Who have Depressive Symptoms
6	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)
8	Prevalence of Long Stay Residents Who Received an Antipsychotic Medication (As Risk Adjusted by the Commissioner)
9	Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner)
10	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
11	Percent of Long Stay Residents with a Urinary Tract Infection
12	Percent of Employees vaccinated for the Flu

New York
110(d)(22)

13	Composite Staffing Measure • Percent Level of Temporary Contract Staff
14	Composite Staffing Measure • CMS Five Star Rating for Staffing
	Compliance Measures
15	5-Star Rating for Health Inspections for April 2013
16	Timely Submission and Certification of 2012 New York State Nursing Home Cost Report to the Commissioner
17	Timely Submission of Employee Flu Data for September 1, 2012 - March 31, 2013
	Potentially Avoidable Hospitalization Measures
18	Rate of Potentially Avoidable Hospitalizations for Long Stay Episodes January 1, 2012 – December 31, 2012

The maximum points a facility may receive for the Quality Component is 60 points. The applicable percentages for each of the 14 measures shall be determined for each facility and shall be ranked and grouped by quintile with points awarded as follows:

Scoring for 14 Quality Measures	
Quintile	**Points**
1st Quintile	4.62
2nd Quintile	2.77
3rd Quintile	.92
4th Quintile	0
5th Quintile	0

Note: Flu and pneumococcal vaccine quality measures will not be ranked into quintiles. The facilities are awarded maximum points if the rate is 85% or greater, and zero points if the rate is less than 85%.

New York
110(d)(23)

The maximum points a facility may receive for the Compliance Component is 20 points. Points shall be awarded as follows:

Scoring for Compliance Measures	
5 Star Rating for Health Inspections	**Points**
5 Stars	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
Submission of Timely Filed and Certified Cost Report	5 (Facilities that fail to submit a cost report will receive zero points)
Timely submission of Employee Flu Data	5 (Facilities that fail to submit flu data will receive zero points)

The maximum points a facility may receive for Potentially Avoidable Hospitalizations is 20 points. The rates of potentially avoidable hospitalizations shall be determined for each facility and each such rate shall be ranked and grouped by quintile with points awarded as follows:

Scoring for Potentially Avoidable Hospitalizations Measure	
Quintile	**Points**
1st Quintile	20
2nd Quintile	16
3rd Quintile	12
4th Quintile	4
5th Quintile	0

The following rate adjustments, which shall be applicable to the 2013 calendar year, shall be made to fund the quality pool and to make quality payments based upon the scores calculated as described above.

- Each such non-specialty facility, as defined by this paragraph, shall be subject to a negative per diem adjustment to fund the quality pool which shall be calculated as follows:

New York
110(d)(24)

- For each such facility, facility Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days as reported in a facility's most recently available cost report, will be divided by total Medicaid revenues of all qualified facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days.

- The total quality scores as calculated above for each such facility shall be ranked and grouped by quintile. Each of the top three quintiles shall be allocated a share of the $50 million quality pool and each such facility within such top three quintiles shall receive a quality payment. Such quality payment shall be paid as a per diem adjustment for the 2013 calendar year. Such shares and payments shall be calculated as follows:

Distribution of Quality Pool and Quality Payments				
Facilities Grouped by Quintile	**A**	**B Percent Share of $50 Million Quality Pool Allocated to Quintile**	**C Facility Payments**	**D Facility Per Diem Quality Adjustment**
1st Quintile	Sum of: Each facility's 2012 Medicaid days* 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by 3	Column A Divided by Sum of Total Medicaid Revenue Multiplied by $50 million	For each facility 2012 Medicaid days Divided by Total Medicaid Days of all the Facilities in Quintile Multiplied by the Column B	For each facility, Column C divided by 2012 Medicaid Days
2nd Quintile	Sum of: Each facility's 2012 Medicaid days* 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by 2	Column A Divided by Sum of Total Medicaid Revenue Multiplied by $50 million	For each facility 2012 Medicaid days Divided by Total Medicaid Days of all the Facilities in Quintile Multiplied by the Column B	For each facility, Column C divided by 2012 Medicaid Days
3rd Quintile	Sum of: Each facility's 2012 Medicaid days* 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by 1	Column A Divided by Sum of Total Medicaid Revenue Multiplied by $50 million	For each facility 2012 Medicaid days Divided by Total Medicaid Days of all the Facilities in Quintile Multiplied by the Column B	For each facility, Column C divided by 2012 Medicaid Days
Total Revenue as Calculated in Column A	Sum of Total Medicaid Revenue	100%	--	--

New York
110(d)(25)

The following facilities shall not be eligible for 2013 quality payments and the scores of such facilities shall not be included in determining the share of the quality pool or facility quality payments.

- A facility that receives a J/K/L survey deficiency during the measurement year or payment year.
- A facility that receives a determination of fraud or abuse by the Office of the Medicaid Inspector General or Attorney General's Medicaid Fraud Control Unit during the measurement year or the payment year.

Appendix II
2013 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #12-29

This State Plan Amendment proposes to provide an incentive for nursing homes to improve quality by linking payments to quality. Effective with the 2013 rate year, the Amendment will define quality measures, develop a methodology to establish quality scores against those measures and make quality payments to nursing homes. The SPA will also clarify the reporting requirements related to the 2012 quality adjustments.

Appendix III
2013 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

SPA 12-29

PUBLIC HEALTH LAW - 2808 2-c(d)

2-c. (a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of federal financial participation, the non-capital component of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on or after October first, two thousand eleven, but no later than January first, two thousand twelve, shall reflect a direct statewide price component, and indirect statewide price component, and a facility specific non-comparable component, utilizing allowable operating costs for a base year as determined by the commissioner by regulation. Such rate components shall be periodically updated to reflect changes in operating costs.

(b) The direct and indirect statewide price components shall be adjusted by a wage equalization factor and such other factors as determined to be appropriate to recognize legitimate cost differentials and the direct statewide price component shall be subject to a case mix adjustment utilizing the patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law. Such wage equalization factor shall be periodically updated to reflect current labor market conditions.

(c) The non-capital component of the rates for: (i) AIDS facilities or discrete AIDS units within facilities; (ii) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; (iii) discrete units providing specialized programs for residents requiring behavioral interventions; (iv) discrete units for long-term ventilator dependent residents; and (v) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall reflect the rates in effect for such facilities on January first, two thousand nine, as adjusted for inflation and rate appeals in accordance with applicable statutes, provided, however, that such rates for facilities described in subparagraph (i) of this paragraph shall reflect the application of the provisions of section twelve of part D of chapter fifty-eight of the laws of two thousand nine, and provided further, however, that insofar as such rates reflect trend adjustments for trend factors attributable to the two thousand eight and two thousand nine calendar years the aggregate amount of such trend factor adjustments shall be subject to the provisions of section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities.

Appendix IV
2013 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
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
Village of Geneseo

The Village of Geneseo is soliciting proposals for a full financial statement audit. The Village's annual operating budget amounts to $5,036,673 and encompasses general, water and sewer funds. A trust and agency payroll account exists as well as several reserve and capital project funds. We would request that the court records are also audited in compliance with Section 2019-a of the Uniform Justice Court Act.

Please submit proposals to the Village of Geneseo, Marsha Merrick, Village Clerk/Treasurer, 119 Main St., Geneseo, NY 14454. Questions may be directed to 585-243-1177 or emailed to village@geneseony.org.

All proposals must be received no later than December 28, 2012. The goal is to review those proposals and select a firm in January 2013.

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, long term care, non-institutional and pharmacy services to comply with proposed and enacted statutory provisions. The following changes are proposed:

General

- Consistent with Section 1202 of the Affordable Care Act, certain primary care providers (e.g., physicians, physician's assistants and nurse practitioners) will be reimbursed at the Medicare rate for Medicaid primary care services furnished in calendar years 2013 and 2014 in institutional and non-institutional settings. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The purpose of this provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014. It is estimated that this provision will infuse $11 billion into Medicaid primary care nationally and is 100 percent funded by the federal government through an enhanced federal financial participation (FFP) rate. The rate increase will significantly bolster the primary care delivery system, potentially increasing access for current and new Medicaid beneficiaries and reducing unnecessary visits to the emergency department.

The State is currently developing the impact to the provider community and will issue a clarification notice once such impact has been determined.

Institutional Services

- For the period effective January 1, 2013 through December 31, 2015, indigent care pool payments will be made using an uninsured units methodology. Each hospital's uncompensated care need amount will be determined as follows:
  - Inpatient units of service for the cost report period two years prior to the distribution year (excluding hospital-based residential health care facility (RHCF) and hospice) will be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year;
  - Outpatient units of service for the cost report period two years prior to the distribution year (excluding referred ambulatory and home health) will be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year;
  - Inpatient and outpatient uncompensated care amounts will then be summed and adjusted by a statewide adjustment factor and reduced by cash payments received from uninsured patients; and
  - Uncompensated care nominal need will be based on a weighted blend of the net adjusted uncompensated care and the Medicaid inpatient utilization rate. The result will be used to proportionately allocate and make Medicaid disproportionate share hospital (DSH) payments in the following amounts:

$139.4 million to major public general hospitals, including hospitals operated by public benefit corporations; and

$994.9 million to general hospitals, other than major public general hospitals.

This initiative will be transitioned in over three years from the existing methodology to the uninsured units methodology.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- For eligible public general hospitals effective beginning January 1, 2013 and subsequent calendar years, the Indigent Care Adjustment will be allocated proportionately based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available data reported to the Department of Health as required by the Commissioner on a specified date through the Data Collection Tool.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Extends effective beginning April 1, 2013 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Effective beginning April 1, 2013 and for state fiscal years thereafter, the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals, increases to $339 million annually.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is $25 million.

Long Term Care Services

- Effective with the 2013 rate year, the Department of Health will implement quality measures and benchmarks and against those parameters make payments related to the implementation of a Quality Pool for non-specialty residential health care facilities (i.e., non-specialty nursing homes). The quality measures and benchmarks used to score and measure nursing home quality will include the following three categories.

1) Quality MDS Measures - will be calculated using data from MDS 3.0 data, New York State employee flu vaccination data, and the Centers for Medicare & Medicaid Services (CMS) 5-Star staffing measure;

2) Compliance Measures - will be calculated using data from the CMS' 5-Star Rating for health inspections, the timely filing of certified nursing home cost reports, and the timely filing of employee flu immunization data; and

3) Avoidable hospitalizations - will be calculated using MDS 3.0 data, and will be based upon a potentially preventable hospitalization quality indicator for short and long stay hospitalizations.

The scores will be based upon performance in the current year (as defined by the measures and the time period for which data is available) and improvements from the prior year. Certain nursing homes, including those which receive a survey outcome of immediate jeopardy, or substandard quality of care, a J, K, or L deficiency will be not be eligible for quality payments. Funding for the quality payments will be made from a redistribution of existing resources paid through the nursing home pricing methodology to non-specialty nursing homes, and as a result, the Quality Pool will not have an impact on annual gross Medicaid expenditures.

Non-Institutional Services

- Effective January 1, 2013, the State will be adding a new reimbursement methodology for providers who are participating in a Medicaid program integrating the delivery of physical and behavioral health services at a single clinic site.

The goal of this program is to improve the quality and coordination of care provided to individuals who have multiple physical and behavioral health needs. Presently, individuals with serious mental illness and/or addictions often receive regular care in specialized behavioral health settings. The specific clinic site in which these services are provided is licensed to provide such services by the Office of Mental Health (OMH) or the Office of Alcohol and Substance Abuse Services (OASAS) and is not licensed or authorized to provide physical/medical care under Article 28 of the Public Health Law. Patients receiving treatment in these clinics may therefore forgo primary care or, when they do receive physical/medical health care from an Article 28 Department of Health (DOH) certified clinic, the DOH certified clinic site is separate and distinct from the behavioral health clinic site. This leads to fragmented care, poorer health outcomes, and higher rates of emergency room and inpatient services. The goal of this program is to facilitate and promote the availability of both physical and behavioral health services at the site where that individual receives their regular care. For example, if an individual receives regular care in a mental health or substance abuse clinic, that clinic will now be authorized to provide both the physical/medical as well as behavioral health services required by that individual.

A number of steps will be undertaken by DOH, OMH and OASAS to facilitate and streamline this health care delivery model. DOH, OMH and OASAS will work together to:

- Provide an efficient approval process to add new services to a site that is not licensed for those services;
- Establish a single set of administrative standards and survey process under which providers will operate and be monitored; and
- Provide single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site.

To insure quality and coordination of care provided to people with multiple needs, DOH, OMH and OASAS will:

- Ensure appropriate compliance with applicable federal and State requirements for confidentiality of records;
- Work with providers to ensure optimal use of clinical resources jointly developed by OASAS and OMH that support evidence based approaches to integrated dual disorders treatment; and
- Provide an opportunity for optimal clinical care provided in a single setting creating cost efficiencies and promoting quality of care.

Providers eligible to participate in the program include those with two or more licenses at different physical locations, providers who have co-located clinics (i.e., two separately licensed clinics that operate in the same physical location) and providers who are licensed by one State agency but choose to provide an array of services that would fall under the license or certification of another State agency.

Participating providers will be paid through the Ambulatory Patient Group (APG) reimbursement methodology when offering integrated services at an authorized clinic site. Recognizing that integration of physical and behavioral services may result in lower clinic patient billing volume, OMH and OASAS providers will have their APG payment blend accelerated so that they will now receive a 100% calculated APG payment instead of a blended payment - 25% or 50% of existing payment for blend/75% or 50% of APG payment (Note: DOH clinics are already receiving 100% APG payment with no blend). Additionally, the overall APG calculated payment for all providers will be increased by 5%.

The DOH projects that the new payment methodology will be cost neutral.

- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after January 1, 2013.

There is no estimated annual change to gross Medicaid expenditures attributable to this initiative in state fiscal year 2013/14.

- Effective January 1, 2013, Medicaid will provide reimbursement to hospital and diagnostic and treatment center physicians for providing home visits to chronically ill patients.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

Pharmacy

- The Department of Health proposes to remove coverage of benzodiazepines as well as barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries, effective January 1, 2013.

Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage, effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, New York State (NYS) proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/2014 is ($1,983,863).

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

The public is invited to review and comment on this proposed State Plan Amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, 99 Washington Ave. - One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

The State proposes to make the following changes effective February 1, 2013. The State will expand the applicability of the reporting and audit requirements in OPWDD regulations to cover Medicaid Service Coordination (MSC), Home and Community Based Services Waiver services (HCBS Waiver services), and clinic treatment facilities (''Article 16 clinics'') provided under the auspices of OPWDD. Additionally, the State proposes to reduce the number of cost report filing deadline extensions from two thirty-day extensions to one thirty-day extension. The State proposes to change the penalty for failure to file a cost report on time from a 5 percent penalty imposed at the discretion of the State and levied against the operating portion of existing rates, prices or fees, to a 2 percent mandatory reduction in reimbursements.

Another proposed change will require OPWDD to give the provider written notice that it missed the cost report deadline or that it must submit a revised cost report. This notice will give the provider a final opportunity to submit the cost report or explain that it cannot submit it because of unforeseeable factors beyond its control. If the provider submits the cost report or shows that there were unforeseeable factors beyond its control that prevented it from submitting on time, it will avoid the penalty. However, the penalty will be imposed if the provider submits an explanation of the unforeseeable factors and OPWDD sets a new deadline for the cost report, but the provider misses this new deadline.

The State would also change the procedures in cases where it is the provider that discovers that a cost report is incomplete, inaccurate or incorrect, and where the provider makes this discovery before receiving its new base period rate, fee or price. The change will eliminate the requirement that the provider first give OPWDD notice and then follow up with a revised cost report within 30 days. Instead, the provider will simply submit a revised cost report. Also, the change will eliminate the penalty in this situation, but keep the provision that allows, rather than requires, that OPWDD revise the rate, fee or price based on the revised cost data, and then only if and when OPWDD receives the revised cost report.

Finally, the State is proposing to clarify that service-specific records of expenditures and revenues must be kept at the program or site level, that providers must maintain underlying records which formed the basis for or which support the cost, budget and other reports and data submitted to OPWDD, that reports and records that were not used to establish a rate, price or fee must be kept until the later of six years from the due date or date of submission, and that reports and records that were used to establish a rate, price or fee must be kept for six years after the rate, price or fee was set.

The State does not expect this change to result in any aggregate increases or decreases in Medicaid expenditures.

The reasons for the proposed changes are as follows. The State is proposing to expand the reporting and audit requirements to MSC, HCBS Waiver services and Article 16 clinics because the State's regulations governing financial reporting, record keeping and audit requirements were promulgated in 1998. Since then, OPWDD has developed new services and existing services have been substantially changed.

The State is proposing to reduce the number of cost report deadline extensions from two to one to bring regulations in line with actual OPWDD practices.

The State is proposing the changes on sanctions for providers which fail to meet the deadlines because the current discretionary penalty has not been imposed and as a result, late filers do exist. Not only does this disrupt the efficient flow of rate setting operations, but providers need to examine the financial results of their operations at least on an annual basis to measure, assess and react to the factors influencing their financial health and to forge budgets and define their fiscal direction. OPWDD wants to assure that the compilation and submission of financial data occurs on a timely basis.

The State is proposing to apply the percentage reduction to reimbursements because this will not require that prices, rates and/or fees be recalculated and reissued. In contrast, the current system of applying reductions to a rate, price or fee requires that the State recalculate and reissue rates.

The State is proposing that OPWDD give the provider notice that it missed the cost report deadline or that it must submit a revised cost report, and that the provider have a final opportunity to submit the cost report or explain why it cannot submit it, because this will be both a fair and effective way of ensuring that penalties are imposed only on those providers that are truly at fault.

The State is proposing to change the procedures when the provider discovers that a cost report is incomplete, inaccurate or incorrect to increase efficiency. The State is proposing to eliminate the penalty in this situation in the interests of fairness.

The State is proposing the clarifications to requirements for the records that providers must keep so that these requirements will be better understood and so that there will be adequate records for the State to exercise necessary oversight of Medicaid funding.

Outside New York City, a detailed description of the changes is available for public review at the following addresses:

Albany
Albany County Department of Mental Health

Appendix V
2013 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment 12-29

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of your state plan.

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 amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either 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 government 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 payments authorized for this provision are not supplemental or enhanced payments.

4. **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. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2012.

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: Effective January 1, 2012, the rate methodology included in the approved state plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage differentials (WEF). Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost based methodology. 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: This SPA 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 will be forwarded to CMS. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.