NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 21, 2013

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

RE: SPA #13-24
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-24 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2013 (Appendix I). This amendment is being submitted based on enacted legislation. 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 enacted 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 March 27, 2013, 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: **13-24**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 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 04/01/13-09/30/13 $ 51,500,000** **b. FFY 10/01/13-09/30/14 $ 103,000,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)**

10. SUBJECT OF AMENDMENT:
2012 Cost Containment – LTC (inc. Ext of NH Cash Assessment)
(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: June 21, 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
Second Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value shall be called the 1999 statewide target percentage.

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, [and] February 1, 2013, February 1, 2014, and February 1, 2015, the Commissioner of Health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015, statewide target percentage respectively.

(2) Prior to February 1, 1996, the Commissioner of Health shall calculate the results of the statewide total of health care facility

New York
47(x)(11)

1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

(c) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013, statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015, statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

(d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

New York
47(x)(12)

(4) (a) The 1995 statewide reduction percentage shall be multiplied by $34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage shall be multiplied by $68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.

(c) The 1997 statewide reduction percentage shall be multiplied by $102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.

(d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013, statewide reduction percentage shall be multiplied by $102 million respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013, statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and]2013, 2014 and 2015, statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015 statewide reduction amount.

New York
47(x)(13)

(e) The 1999 statewide reduction percentage shall be multiplied by $76.5 million to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013, statewide aggregate reduction amounts shall for each year be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015, target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point increase in the 1996, a three percentage point increase in the 1997, and a

three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015, target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015, facility specific reduction amounts respectively.

(6) The facility specific reduction amounts shall be due to

New York
51(a)(1)

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

(h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 30, 2015, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

(i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

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*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

New York
110(E)(1)

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities shall be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, [and] April 1, 2005 through March 31, 2013, and April 1, 2013 through March 31, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), shall be 6%, 5%, [and] 6%, and 6%, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments.[1]

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[1]The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

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

SUMMARY
SPA #13-24

This State Plan Amendment proposes to extend through 2015 the following cost containment provisions.

- Trend Factor – Continues the elimination of the trend factor for the period April 1, 1996 through March 31, 1997 in rates of payment;

- .25% reduction to the 2006 trend factor continues;

- Statewide Target Percentage – Continues the current calculation methodology for the statewide target percentage for Medicare maximization through 2015; and

- Extends the reimbursable assessment on RHCF gross receipts received from all patient care services and other operating income on a cash basis through March 31, 2015.

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

CHAPTER 56 OF THE LAWS OF 2013 - PART B

§ 5. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 102 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent**.

§ 9. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 9 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

§ 194. 1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 **and on and after April 1, 2013 through March 31, 2015** shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

2. The commissioner of health shall adjust such rates of payment to reflect the exclusion pursuant to this section of such specified trend factor projections or adjustments.

§ 10. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 10 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regu-

lation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

§ 11. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, [and] February 1, 2013 and February 1, 2014 and February 1, 2015 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015 statewide target percentage respectively.

§ 12. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 and 2015 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013; 2014 and 2015 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

§ 13. Subparagraph (iii) of paragraph (b) of subdivision 4 of section

64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** reduction amount.

§ 14. Paragraph (b) of subdivision 5 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 14 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [~~and~~] 2013**, 2014 and 2015** facility specific reduction amounts respectively.

Appendix IV
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Public Notice

• Continues, effective April 1, 2013 through March 31, 2015, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $114.5 million.

• Effective April 1, 2013, rates of payments for general hospitals certified by the Office of Alcoholism and Substance Abuse Services who provide inpatient detoxification and withdrawal services and, for inpatient services provided for patients discharged on and after December 1, 2008, and who are determined to be in diagnosis-related groups as identified and published on the New York State Department of Health website will be made on a per diem basis. Such payments will be made in accordance with existing methodology previously noticed on June 10, 2009.

• The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on January 1, 2014.

• Effective January 1, 2014, the payment rates for hospital DRG exempt services may be adjusted periodically to reflect a more current cost and statistical base year including adjustments deemed necessary by the Commissioner.

• Effective January 1, 2014, hospital inpatient payment rates may be adjusted to include changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displace and transferred as a result of a teaching hospital closure.

• Continues, effective January 1, 2014, the current methodology established to incorporate quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), shall be calculated in accordance with the existing methodology.

- Such methodology will be based on a risk adjusted comparison of the actual and the expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner.

- Such rate adjustments or payment disallowances will result in an aggregate reduction in Medicaid payments of no less than $51 million for the period April 1, 2013 through March 31, 2014.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2013 through March 31, 2014 and as a result of decreased PPNOs during the period April 1, 2013 through March 31, 2014. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• Continues, effective for periods April 1, 2013 through March 31, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The annual increase in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $420 million.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2013 through March 31, 2015, long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $117 million.

• Extends the provision, cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate will be subject to audit through December 31, 2018. Facilities will therefore retain all fiscal and statistical records relevant to such cost reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

• For state fiscal years beginning April 1, 2013, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that, in consultation with impacted providers, of the funds allocated for distribution in state fiscal year beginning April 1, 2013, up to $32 million may be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made for state fiscal year periods beginning April 1, 2006. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Non-institutional Services

• For state fiscal year beginning April 1, 2013 through March 31, 2014, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for adult day health services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2013 through March 31, 2015.

• Continues, effective April 1, 2013 through March 31, 2015, home health care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $17.8 million.

• The current authority to adjust Medicaid rates of payment for services provided by certified home health agencies (CHHAs) for such services provided to children under 18 years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2013 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for such period, and shall be calculated in accordance with the previously approved methodology.

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

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #13-24

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 will submit the current nursing home UPL demonstration by June 30, 2013.

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 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
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Access Questions

APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 13-24

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-D 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 continue cost saving measures previously enacted. This is an overall effort to control Medicaid spending. the change should not significantly impact providers since overall rates are being held constant, not being reduced.

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, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) 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 sufficient 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 2013-14 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.

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: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million 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. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). 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.