NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

June 30, 2014

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

RE: SPA #14-18
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-18 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2014 (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 legislation is enclosed for your information (Appendix III). A copy 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: **14-18**	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, 2014**	
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 04/01/14-09/30/14 $ 0** **b. FFY 10/01/14-09/30/15 $ 0**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(26)**	
10. SUBJECT OF AMENDMENT: **2014 Nursing Home Quality Incentive Pool (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: 13. TYPED NAME: **Jason A. Helgerson** 14. TITLE: **Medicaid Director** **Department of Health** 15. DATE SUBMITTED: June 30, 2014	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**	
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

Appendix I
2014 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
110(d)(21)

p) 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 influenza 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] 2014, the Commissioner shall calculate a quality score, based on quality data from the [2012] 2013 calendar year (January 1, [2012] 2013 through December 31, [2012] 2013), for each non-specialty facility. For purposes of calculating a [2013] 2014 quality score, non-specialty facilities shall exclude non-Medicaid facilities and CMS Special Focus Facilities. 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	Percent of Long Stay Residents Who Received an Antipsychotic Medication
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 Influenza

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13	[Annual Percent Level of Temporary Contract Staff] Annual Level of Temporary Contract/Agency Staff Used
14	CMS Five-Star Quality Rating for Staffing as of April 1, 2014
Compliance Measures	
15	CMS Five-Star Quality Rating for Health Inspections as of April 1, [2013] 2014
16	Timely Submission and Certification of Complete [2012] 2013 New York State Nursing Home Cost Report to the Commissioner
17	Timely Submission of Employee Influenza Immunization Data for the September 1, [2012] 2013 - March 31, [2013] 2014 Influenza Season by the two deadlines of November 15, 2013 and May 1, 2014
Potentially Avoidable Hospitalizations Measure	
18	Rate of Potentially Avoidable Hospitalizations for Long Stay Episodes January 1, [2012] 2013 – December 31, [2012] 2014 (As Risk Adjusted by the Commissioner)

The maximum points a facility may receive for the Quality Component is [60] 70 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	[4.29] 5
2nd Quintile	[2.57] 3
3rd Quintile	[0.86] 1
4th Quintile	0
5th Quintile	0

Note: The long stay resident [seasonal influenza and] pneumococcal vaccine quality measures, and the [annual percent level of temporary contract staff] annual level of temporary contract/agency staff used quality measure will not be ranked into quintiles. For the long stay resident seasonal influenza and pneumococcal measures, the facilities will be awarded maximum points (4.29) if the rate is 85% or greater, and zero points if the rate is less than 85%. For the annual percent level of temporary contract staff measure, the facilities will be awarded maximum points if the rate is less than 10%, and zero points if the rate is 10% or greater.

The following quality measures will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors:

- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain: the covariate includes cognitive skills for daily decision making on the prior assessment.

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110(d)(22.1)

- Percent of Long Stay High Risk Residents with Pressure Ulcers:
  The covariates include gender, age, healed pressure ulcer since the prior assessment, BMI, prognosis of less than six months of life expected, diabetes, heart failure, deep vein thrombosis, anemia, renal failure, hip fracture, bowel incontinence, paraplegia, and quadriplegia.

- Percent of Long Stay Residents who Lose Too Much Weight:
  The covariates include age, hospice care, cancer, renal failure, prognosis of less than six months of life expected

For these three measures the risk adjusted methodology includes the calculation of the observed rate; that is the facility's numerator-compliant population divided by the facility's denominator.

The expected rate is the rate the facility would have had if the facility's patient mix was identical to the patient mix of the state. The expected rate is determined through the risk-adjusted model and follows the CMS methodology found in the MDS 3.0 Quality Measures User's Manual, Appendix A-1.

The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate.

Redistribution of Quality Points: Due to limitations of the nursing home cost reports, DOH cannot accurately calculate the [Annual Percent Level of Temporary Contract Staff] annual level of temporary contract/agency staff used for certain facilities. In these cases, this measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

[Superstorm Sandy had an impact on some facilities' ability to immunize their healthcare workers. For these facilities, the Percent of Employees Vaccinated for Influenza measure will be suppressed if it results in a higher overall score for the facility affected. In this case, the quality points will be redistributed across the remaining quality measures.]

For quality measures with a denominator of less than 30, the measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

Facilities with a missing CMS Five-Star Quality Rating for Staffing will have this measure suppressed and the quality points redistributed to the remaining quality measures.

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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	
CMS Five-Star Quality Rating for Health Inspections	**Points**
5 Stars	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
[Submission of Timely Filed, Certified, and Complete Cost Report] Timely Submission and Certification of Complete 2013 New York State Nursing Home Cost Report to the Commissioner	5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points)
Timely Submission of Employee Influenza Immunization Data	5 total; [5] 2.5 for the November 15, 2013 deadline 2.5 for the May 1, 2014 deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero out of the 2.5 points for that specific deadline)

Redistribution of Compliance Points:

[Superstorm Sandy had an impact on some facilities' ability to submit their employee immunization data by the designated deadline. Facilities that do not submit timely employee flu immunization data due to Superstorm Sandy will not be penalized. In these cases, the points will be redistributed to the timely submission of nursing home certified cost reports measure. This measure will be worth 10 points instead of five.]

Facilities with a missing CMS Five-Star Quality Rating for Health Inspections will have compliance points redistributed to the remaining timely submission measures. In these cases each measure will be worth 10 points.

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110(d)(23.1)

The maximum points a facility may receive for the Potentially Avoidable Hospitalizations Component is [20] 10 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] 10
2nd Quintile	[16] 8
3rd Quintile	[12] 6
4th Quintile	[4] 2
5th Quintile	0

The Potentially Avoidable Hospitalizations measure will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, race/ethnicity, payor, prior hospitalization (hospitalization less than or equal to 90 days before the long stay episode began), pneumonia, urinary tract infection, pressure ulcer, feeding tube, septicemia, parenteral nutrition, indwelling catheter, antibiotic-resistant infection, and Charlson Index*.

*The Charlson Index is a score based on several comorbidities following CMS specifications. In the statistical model, the Charlson Index is separated into the following three groups: Low (a score of less than or equal to 1), Mid (2-4), and High (5 and greater).The comorbidities were determined using (1) any MDS assessment during the resident's long stay episode, or (2) a hospitalization record up to 12 months before the resident's long stay episode began, or (3) a hospitalization record up to three days after the resident's long stay episode ended. The comorbidities used to create the Charlson Index include the following: myocardial infarction, congestive heart failure, peripheral vascular disease, cerbrovascular disease. dementia, chronic pulmonary disease, rheumatolic disease, peptic ulcer disease, mild liver disease, diabetes with complications, diabetes without complications, paraplegia and hemiplegia, renal disease, cancer/leukemia, moderate or severe liver disease, metastatic carcinoma, and AIDS/HIV.

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A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in SPARCS. The following admitting diagnoses on the SPARCS hospital record are potentially avoidable:

Respiratory infections
466 Acute bronchitis
480.0-487.8 Pneumonia
507 Pneumonia
Sepsis
038.0-038.9 Septicemia
UTI
590.00-590.9 Infections of kidney
595.0-595.4 Cystitis
595.9 Cystitis
595.89 Other type of cystitis
597 Urethral abscess
598 Urethral stricture due to infection 598.01 Urethral stricture due to infection
599 Urinary tract infection
601.0-604 Inflammation of prostate
Electrolyte imbalance
276.0-276.9 Disorders of fluid, electrolyte and acid-base balance
CHF
428.0-428.9 Heart Failure
398.91 Rheumatic heart failure
Anemia
280-280.9 Iron deficiency anemias
281.0-281.9 Other deficiency anemias
285.1 Acute posthemorrhagic anemia
285.29 Anemia of chronic illness

The following rate adjustments, which shall be applicable to the [2013] 2014 calendar year, shall be made to fund the quality pool and to make quality payments based upon the scores calculated as described above.

- Specialty facilities, such as AIDS and pediatrics facilities, are excluded from the Quality Pool. Each such non-specialty facility, as defined by this paragraph, shall be subject to a negative per diem adjustment to fund the quality pool. Specialty facility shall mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities

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or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. Non-specialty shall mean all other facilities not defined as a specialty facility. Each such non-specialty facility shall be subject to a negative per diem adjustment to fund the quality pool which shall be calculated as follows: [The negative per diem adjustment shall be calculated as follows:]

- For each such 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 [2012] 2013 cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days. If a facility fails to submit a timely filed [2012] 2013 cost report, the previous year's cost report will be used.

- 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] 2014 calendar year. Such shares and payments shall be calculated as follows:

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110(d)(25.1)

Distribution of Quality Pool and Quality Payments			
Facilities Grouped by Quintile	**A** **Facility's Medicaid Revenue Multiplied by Award Factor**	**B** **Share of $50 Million Quality Pool Allocated to Facility**	**C** **Facility Per Diem Quality Payment**
1st Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = Total Medicaid Revenue multiplied by an award factor of 3	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's [2012] 2013 Medicaid days
2nd Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = Total Medicaid Revenue multiplied by an award factor of 2.25	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's [2012] 2013 Medicaid days
3rd Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = Total Medicaid Revenue multiplied by an award factor of 1.5	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's [2012] 2013 Medicaid days
Total	Sum of Total Medicaid Revenue for all facilities	Sum of quality pool funds: $50 million	--

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110(d)(26)

The following facilities shall not be eligible for 2014 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 with health inspection survey deficiency data showing a level J/K/L deficiency during the time period of July 1, 2013 through June 30, 2014. Deficiencies will be reassessed on October 1, 2014 to allow a three-month window (after the June 30, 2014 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, 2014 and September 30, 2014. Any *new* J/K/L deficiencies between July 1, 2014 and September 30, 2014 will *not* be included in the 2014 Nursing Home Quality Pool [(NHQP)].

q) Per Diem Transition Adjustments: Over the five-year period beginning January 1, 2012, and ending December 31, 2016, non-specialty facilities shall be eligible for per diem transition rate adjustments, calculated as follows:

1) In each year for each non-specialty facility computations shall be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments shall be made for each year such that the difference between such computations for each year is no greater than the percentage as identified in subparagraph (iii) [below], of the total Medicaid revenue received from the non-specialty facility's July 7, 2011, rate (as transmitted in the Department's Dear Administrator Letter (DAL) dated November 9, 2011) and not subject to reconciliation or adjustment, provided, however, that those facilities which are, subsequent to November 9, 2011, issued a revised non-capital rate for rate periods including June 7, 2011, reflecting a new base year that is subsequent to 2002, shall have such revised non-capital rate as in effect on July 7, 2011 utilized for the purpose of computing transition adjustments pursuant to this subdivision.

i) A non-specialty facility's Medicaid revenue, calculated by summing the direct component, indirect component, non-comparable components of the price in

Appendix II
2014 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #14-18

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, quality measures were defined and a methodology was developed to establish quality scores against those measures and make quality payments to nursing homes. This SPA will clarify the reporting requirements related to the 2014 quality adjustments.

Appendix III
2014 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Authorizing Provisions
SPA #14-18

Chapter 60 – Laws of 2014, Part C Section 26-a

§ 26-a. Paragraph (d) of subdivision 2-c of section 2808 of the public health law, as added by section 95 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

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. **For purposes of facilitating quality improvements through the establishment of a nursing home quality pool, those facilities that contribute to the quality pool, but are deemed ineligible for quality pool payments due exclusively to a specific case of employee misconduct, shall nevertheless be eligible for a quality pool payment if the facility properly reported the incident, did not receive a survey citation from the commissioner or the Centers for Medicare and Medicaid Services establishing the facility's culpability with regard to such misconduct and, but for the specific case of employee misconduct, the facility would have otherwise received a quality pool payment. Regulations pertaining to the facilitation of quality improvement may be made effective for periods on and after January first, two thousand thirteen.**

Appendix IV
2014 Title XIX State Plan
Second Quarter Amendment
Public Notice

- 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.

Appendix V
2014 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #14-18

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 are working to finalize the 2013 nursing home UPL demonstration, which the 2014 demonstration is contingent upon. The State will submit the 2014 nursing home UPL demonstration as soon as practicable.

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 the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.