NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 2 7 2016

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

RE: SPA #16-0024
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #16-0024 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2016 (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).

A copy of the pertinent section of proposed 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 30, 2016, 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, Office of Health Insurance Programs 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: **16-0024**	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, 2016**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(r)(5) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/16-09/30/16 $ 0** **b. FFY 10/01/16-09/30/17 $ 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)(22.2), 110(d)(22.3), 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)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26)**

10. SUBJECT OF AMENDMENT:
NH Quality Care Incentive Changes
(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 Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 7 2016	

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
2016 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
110(d)(21)

p) For the calendar year 2016 [2015], the Commissioner will calculate a quality score, based on quality data from the 2015 [2014] calendar year (January 1, 2015 [2014] through December 31, 2015 [2014]), for each non-specialty facility. For purposes of calculating a 2016 [2015] quality score, non-specialty facilities will exclude non-Medicaid facilities and CMS Special Focus Facilities. The quality score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures.

Quality Measures		**Measure Steward**
1	Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner)	CMS
2	Percent of Long Stay Residents Who Received the Pneumococcal Vaccine	CMS
3	Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine	CMS
4	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury	CMS
5	Percent of Long Stay Residents Who have Depressive Symptoms	CMS
6	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder	CMS
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)	CMS
8	Percent of Long Stay Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance (PQA)
9	Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner)	CMS
10	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased	CMS
11	Percent of Long Stay Residents with a Urinary Tract Infection	CMS
12	Percent of Employees Vaccinated for Influenza	NYS DOH

New York
110(d)(22)

13	Percent of Contract/Agency Staff Used	NYS DOH
14	Rate of Staffing Hours per Day [CMS Five-Star Quality Rating for Staffing as of April 1, 2015]	NYS DOH [CMS]
	Compliance Measures	
16	CMS Five-Star Quality Rating for Health Inspections as of April 1, 2016 [2015] (By Region)	CMS
17	Timely Submission and Certification of Complete 2015 [2014] New York State Nursing Home Cost Report to the Commissioner	NYS DOH
18	Timely Submission of Employee Influenza Immunization Data for the September 1, 2015 [2014] - March 31, 2016 [2015] Influenza Season by the deadline of May 1, 2016 [2015]	NYS DOH
	Efficiency Measure	
19	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1, 2015 [2014] – December 31, 2015 [2014] (As Risk Adjusted by the Commissioner)	NYS DOH

The maximum points a facility may receive for the Quality Component is 70. The applicable percentages or ratings for each of the 14 measures will be determined for each facility. Two measures will be awarded points based on threshold values. The remaining 12 measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for 12 Quality Measures	
Quintile	**Points**
1st Quintile	5
2nd Quintile	3
3rd Quintile	1
4th Quintile	0
5th Quintile	0

Note: The following quality measures will not be ranked into quintiles and points will be awarded based on threshold values:

- Percent of employees vaccinated for influenza: facilities will be awarded five points if the rate is 85% or higher, and zero points if the rate is less than 85%.
- Percent of contract/agency staff used: facilities will be awarded five points if the rate is less than 10%, and zero points if the rate is 10% or higher.

New York
110(d)(22.1)

Addition of New Measure to Quality Component

[Percent of Long Stay Antipsychotic Use in Persons with Dementia]

[This measure will replace the current CMS measure, Percent of Long Stay Residents Who Received an Antipsychotic Medication. NYS DOH will follow the measure specifications developed and endorsed by the Pharmacy Quality Alliance Quality Metrics Expert Panel. The measure specifications can be found at http://pqaalliance.org/measures as of June 30, 2015.]

Rate of Staffing Hours per Day

This measure will replace the current CMS Five-Star Quality Rating for Staffing. NYS DOH will calculate an annualized adjusted rate of staff hours per resident per day. For this measure, staff are defined as RNs, LPNs, and Aides. The observed staffing hours will be taken from the 2014 nursing home cost reports. The expected staffing hours will be determined using Resource Utilization Group data on the 2014 MDS 3.0 and the CMS 1995-1997 Staff Time Measurement Study. The observed-to-expected staffing hours will be adjusted using the statewide distribution and the formula adapted from the CMS Five-Star Quality Rating for Staffing at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf . The formula below will be used:

(Hours worked reported from cost reports /# of residents from MDS 3.0) / 365 days

Divided by

((RUG distribution from MDS 3.0*hours from CMS time study)/# of residents from MDS 3.0) / 365 days

[Addition of New Measures for Benchmarking Purposes Only]

[The following two staffing measures will be calculated and reported to nursing homes with the results of the 2015 NHQI. The measures will be reported for benchmarking purposes only and will not factor in to the scoring for the 2015 NHQI.]

[Rate of Nursing Hours per Day]

[NYS DOH will calculate an annualized adjusted rate of staff hours per resident per day. For this measure, staff are defined as RNs, LPNs, and Aides. The observed staffing hours will be taken from the 2014 nursing home cost reports. The expected staffing hours will be determined using Resource Utilization Group data on the 2014 MDS 3.0 and the CMS 1995-1997 Staff Time Measurement Study. The observed-to-expected staffing hours will be adjusted using the statewide distribution and the formula adapted from the CMS Five-Star Quality Rating for Staffing at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf . The formula below will be used as of June 30, 2015:

(Hours worked reported from cost reports /# of residents from MDS 3.0) / 365 days

Divided by

((RUG distribution from MDS 3.0*hours from CMS time study)/# of residents from MDS 3.0) / 365 days]

[Percent of Staff Turnover]

[NYS DOH will calculate an annual average staff turnover rate using 2014 nursing home cost report data. For this measure, staff are defined as full time and contract RNs, LPNs, and Aides. Per diem staff are excluded. NYS DOH will use the staff turnover formula put forth by the Advancing Excellence in America's Nursing Homes Campaign. The staff turnover formula as of June 30, 2015, can be found at https://www.nhqualitycampaign.org/goaldetail.aspx?g=ss#tab2.]

Awarding for Improvement

Nursing homes will be awarded improvement points from previous years' performance in selected measures in the Quality Component only. One improvement point will be awarded for a nursing home that improves in its quintile for a specific quality measure, compared to its quintile in the previous year for that quality measure. Nursing homes that obtain the top quintile in a quality measure will not receive an improvement point because maximum points per measure cannot exceed five. The three [five] quality measures below will not be eligible to receive improvement points:

- [Percent of Long Stay Residents Who Received the Pneumococcal Vaccine (based on threshold in 2014 NHQI)]
- Percent of Employees Vaccinated for Influenza (based on threshold)

New York
110(d)(22.2)

- Percent of Contract/Agency Staff Used (based on threshold)
- [Long Stay Antipsychotic Use in Persons with Dementia (new measure)]
- [CMS Five-Star Quality Rating for Staffing as of April 1, 2015]
- Rate of Staffing Hours per Day (new measure)

The remaining 11 [nine] quality measures that are eligible for improvement points are listed below:

- Percent of Long Stay High Risk Residents With Pressure Ulcers
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- Percent of Long Stay Residents Who have Depressive Symptoms
- Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder
- Percent of Long Stay Residents Who Lose Too Much Weight
- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain
- Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
- Percent of Long Stay Residents with a Urinary Tract Infection
- Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
- Percent of Long Stay Antipsychotic Use in Persons with Dementia
- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine

The grid below illustrates the method of awarding improvement points.

2015 [2014] Performance						
2016 [2015] Performance	Quintiles	1 (best)	2	3	4	5
	1 (best)	5	5	5	5	5
	2	3	3	4	4	4
	3	1	1	1	2	2
	4	0	0	0	0	1
	5	0	0	0	0	0

For example, if 2015 [2014] NHQI performance is in the third quintile, and 2016 [2015] NHQI performance is in the second quintile, the facility will receive four points for the measure. This is three points for attaining the second quintile and one point for improvement from the previous year's third quintile.

Risk Adjustment of Quality Measures

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.
- 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, cancer, paraplegia, and quadriplegia.

New York
110(d)(22.3)

- 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.

Reduction of Points Base: When a quality measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen in the following scenarios:

- When nursing homes do not have enough cost report data to calculate a percent of contract/agency staff used or the rate of staffing hours per day; or
- When a quality measure has a denominator of less than 30

New York
110(d)(23)

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

Scoring for Compliance Measures	
CMS Five-Star Quality Rating for Health Inspections (By Region)	**Points**
5 Stars	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
Timely Submission and Certification of Complete 2015 [2014] 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 for the May 1, 2016 [2015] deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero points)

CMS Five-Star Quality Rating for Health Inspections
The CMS Five-Star Quality Rating for Health Inspections as of April 1, 2016 [2015] will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS' methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Central New York Regional Offices (CNYRO): Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.

Capital District Regional Offices (CDRO): Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

New York
110(d)(23.1)

Western New York Regional Offices (WRO): Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates.

Reduction of Points Base: When a compliance measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen when a facility does not have a CMS Five-Star Quality Rating for Health Inspections.

The maximum points a facility may receive for the Efficiency Component is 10 points. The rates of potentially avoidable hospitalizations will be determined for each facility and each such rate will be ranked and grouped by quintile with points awarded as follows:

Scoring for Efficiency Measure	
Quintile	**Points**
1st Quintile	10
2nd Quintile	8
3rd Quintile	6
4th Quintile	2
5th Quintile	0

The Efficiency Measure will be risk adjusted for certain conditions chosen from a pool of covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, shortness of breath, falls with injury, pressure ulcer, activities of daily living, renal disease, cognitive impairment, dementia, diabetes, parenteral nutrition, rheumatologic disease, gastrointestinal disease, multi-drug-resistant infection, indwelling catheter, wound infection, deep vein thrombosis, cancer, feeding tube, coronary artery disease, liver disease, paralysis, peripheral vascular disease, and malnutrition.

New York
110(d)(24)

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 primary 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
99591-99592 Severe Sepsis
78552 Septic Shock
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

Reduction of Points Base: When the number of long stay residents that contribute to the denominator of the potentially avoidable hospitalization measure is less than 30, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base.

The following rate adjustments, which will be applicable to the 2016 [2015] calendar year, will be made to fund the NHQI and to make quality payments based upon the scores calculated as described above.

- Specialty facilities, such as AIDS and pediatrics facilities, and discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children, are excluded from the NHQI. Each such non-specialty facility, as defined by this paragraph, will be subject to a negative per diem adjustment to fund the NHQI. Specialty facility will 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

or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. Non-specialty will mean all other facilities not defined as a specialty facility. Each such non-specialty facility will be subject to a negative per diem adjustment to fund the NHQI which will 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 2015 [2014] 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 2015 [2014] cost report, the previous year's cost report will be used.

- The total quality scores as calculated above for each such facility will be ranked and grouped by quintile. Each of the top three quintiles will be allocated a share of the $50 million NHQI and each such facility within such top three quintiles will receive a quality payment. Such quality payment will be paid as a per diem adjustment for the 2016 [2015] calendar year. Such shares and payments will be calculated as follows:

New York
110(d)(25.1)

Distribution of NHQI and Quality Payments			
Facilities Grouped by Quintile	**A Facility's Medicaid Revenue Multiplied by Award Factor**	**B Share of $50 Million NHQI Allocated to Facility**	**C Facility Per Diem Quality Payment**
1st Quintile	Each facility's 2015 [2014] Medicaid days multiplied by 2016 [2015] Medicaid Rate as of January 1, 2016 [2015] = 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 2015 [2014] Medicaid days
2nd Quintile	Each facility's 2015 [2014] Medicaid days multiplied by 2016 [2015] Medicaid Rate as of January 1, 2016 [2015] = 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 2015 [2014] Medicaid days
3rd Quintile	Each facility's 2015 [2014] Medicaid days multiplied by 2016 [2015] Medicaid Rate as of January 1, 2016 [2015] = 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 2015 [2014] Medicaid days
Total	Sum of Total Medicaid Revenue for all facilities	Sum of quality pool funds: $50 million	--

Payments made pursuant to this program will be subject to this rate adjustment and will be reconciled using actual Medicaid claims data.

New York
110(d)(26)

The following facilities will not be eligible for 2016 [2015] quality payments and the scores of such facilities will not be included in determining the share of the NHQI 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, 2015 [2014] through June 30, 2016 [2015]. Deficiencies will be reassessed on October 1, 2016 [2015] to allow a three-month window (after the June 30, 2016 [2015] cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, 2016 [2015] and September 30, 2016 [2015]. Any *new* J/K/L deficiencies between July 1, 2016 [2015] and September 30, 2016 [2015] will *not* be included in the 2016 [2015] NHQI.

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

1) In each year for each non-specialty facility computations will be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments will 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), 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, will 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
2016 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #16-0024

This State Plan Amendment proposes to maintain the quality incentive for nursing homes into the 2016 rate year and will continue to recognize improvement in performances as an element in the program and provide for other minor modifications. This SPA will clarify the reporting requirements related to the 2016 quality adjustments.

Appendix III
2016 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Authorizing Provisions
SPA #16-0024

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
2016 Title XIX State Plan
Second Quarter Amendment
Public Notice

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($12 million).

• Effective on or after April 1, 2016, a new specialty rate will be implemented for the Neurodegenerative disease population. The population shall include only those patients who are diagnosed with Huntington's disease (HD) and Amyotrophic Lateral Sclerosis (ALS). Individuals within New York State that have neurodegenerative motor function disorders (and their families/caretakers) will have access to comprehensive and coordinated outpatient and inpatient services within New York State throughout the continuum of the disease.

The rate has been created to enable participating providers to deliver more appropriate and necessary care to those residents who have been diagnosed with Huntington's or Amyotrophic Lateral Sclerosis.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $6.3 million.

• The quality incentive program for non-specialty nursing homes will continue for the 2016 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2016/17.

Non-Institutional Services

• For state fiscal year beginning April 1, 2016 through March 31, 2017, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, 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 amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments may be added to rates of payment or made as aggregate payments.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Early Intervention Program rates for approved services rendered on or after April 1, 2016 shall be increased by one percent. The rate increase adjusts for additional administrative activities required of providers for billing and claiming of approved Early Intervention services associated with the implementation of a State Fiscal Agent.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $2.4 million.

• Effective April 1, 2016, eligibility procedures will be streamlined for infants and toddlers referred to the Early Intervention Program (EIP). Children referred to the EIP will be screened to determine whether the child is suspected of having a disability and requires a multidisciplinary evaluation to determine eligibility. Children referred to the EIP with a diagnosed condition with a high probability of developmental delay that establishes the child's eligibility for the program will not be screened and will receive an abbreviated multidisciplinary evaluation. New screening and evaluation rates are being established. Until such time as new screening and evaluation rates are established, existing rates for screening and supplemental evaluation rates will be used to reimburse for these services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/17 is ($5.4 million).

• Effective April 1, 2016, in accordance with an amendment to Section 367-a(1)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service for a member that only has Medicaid coverage.

Currently, the Medicaid program pays the full co-payment or co-insurance amounts for Medicare Part C claims, even when the provider has received more than the amount the Medicaid program would have paid for that service. Under the new limitations, the Medicaid program would not pay any co-payment/co-insurance amount if the provider received payment equal to or greater than the Medicaid amount. The provider would be required to accept the Medicare Part C health plan payment as payment in full for the service and the member could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

The estimated annual net aggregate decrease in Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($22.9 million) gross.

• Effective April 1, 2016, the Department of Health will increase access, and improve education/outreach, for the comprehensive coverage and promotion of long acting reversible contraception (LARC) by requiring separate payments be made for the cost of post-partum LARC methods to providers and allowing Federally Qualified Health Centers (FQHCs) providers to be paid for the cost of LARC in addition to the PPS rate.

Long acting reversible contraception (LARC) methods include the intrauterine device (IUD) and the birth control implant. According to The American College of Obstetricians and Gynecologists (ACOG), both methods are highly effective in preventing pregnancy and are reversible.

Potential savings would result from a reduction in unintended pregnancies and better spacing between pregnancies (improved health outcomes for baby and mother). In particular, increasing use of LARC in the adolescent population has significant potential to reduce unintended pregnancies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative in the budget for state fiscal year 2016/2017 is ($12.6 million).

• Effective on or after April 1, 2016, the State will claim additional FMAP for certain services provided to managed care recipients. CMS authorizes states to claim 1% additional FMAP for USPSTF A&B recommended preventive services when there is no cost-sharing. The State Plan will be amended so that the additional 1% FMAP can be claimed for all USPSTF A&B recommended preventative services provided to managed care recipients for which there is no cost sharing.

Prescription Drugs:

• Effective April 1, 2016, establish price ceilings on critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers. When a critical prescription drug dispensed to a NYS Medicaid enrollee (managed care or fee-for-service) exceeds the ceiling price for the drug, the drug manufacturer will be required to provide rebates to the Department, in

Appendix V
2016 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #16-0024

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: The Nursing Home Quality Pool is paid through a proportionate reduction to nursing home rates of $50M and a reallocation of the fund to those facilities which score in the top three quintiles. The funds are general Medicaid fund paid though the geriatric rates.

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 are not enhancements to the rates in that no additional monies are expended to fund or pay the NHQI. The pool is self-

funded and reallocates the proceeds proportionately from all nursing facilities to those in the top three quintiles.

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: The State is currently working with CMS to finalize the 2014 nursing home UPL demonstration which the 2015 demonstration is contingent upon

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, 2015.

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 State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health**

Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 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.